FILED
Date _____
Time _____
Clerk _____
Comm. Amdt. _____
_____

Amendment No. 1 to SB0460

Cooper J
Signature of Sponsor

AMEND Senate Bill No. 460* House Bill No. 1439

By deleting in its entirety all language following the enacting clause and by substituting instead the following:

SECTION 1. Tennessee Code Annotated, Title 56, Chapter 7, is amended by adding the following as a new section:

56-7-110 (a) As used in this part:

(1) "Covered person" means a person on whose behalf a health insurance entity offering health insurance coverage is obligated to pay benefits or provide services.

(2) "Health insurance coverage" has the same meaning as in § 56-7-109.

(3) "Health insurance entity" has the same meaning as in § 56-7-109.

(4) "Health care provider" means any person or entity performing services regulated pursuant to title 63 or title 68, chapter 11.

(5) "Retroactive denial of a previously paid claim" or "retroactive denial of payment" means any attempt by a health insurance entity retroactively to collect payments already made to a healthcare provider with respect to a claim by reducing other payments currently owed to the health care provider, by withholding or setting off against future payments, by demanding payment back from a health care provider for a claim already paid

FILED
Date _____
Time _____
Clerk _____
Comm. Amdt. _____
_____

Amendment No. 1 to SB0460

Cooper J
Signature of Sponsor

AMEND Senate Bill No. 460* House Bill No. 1439

or in any other manner reducing or affecting the future claim payments to the health care provider.

(6) "Recoupment" means the action by a health insurance entity to recover amounts previously paid to a health care provider by withholding or setting off such amounts against current payments to the health care provider.

(b) A health insurance entity shall not be required to correct a payment error to a health care provider if the provider's request for a payment correction is filed more than eighteen (18) months after the date that the health care provider received payment for the claim from the health insurance entity.

(c) Except in cases of fraud committed by the health care provider, a health insurance entity may only retroactively deny reimbursements to the provider during the eighteen (18) month period after the date that the health insurance entity paid the claim submitted by the health care provider.

(d) A health insurance entity that retroactively denies reimbursement to a health care provider under this section shall give the health care provider a written or electronic statement specifying the basis for the retroactive denial and the statement shall contain, at a minimum, the information required by subsection (g) of this section.

FILED
Date _____
Time _____
Clerk _____
Comm. Amdt. _____
_____

Amendment No. 1 to SB0460

Cooper J
Signature of Sponsor

AMEND Senate Bill No. 460* House Bill No. 1439

(e) If a health insurance entity determines that payment was made for services not covered under the covered person's health insurance coverage, the health insurance entity shall give written notice to the health care provider of its intent to retroactively deny a previously paid claim and may:

(1) Request a refund from the health care provider; or

(2) Make a recoupment of the payment from the health care provider in accordance with subsection (g).

The notice required by this subsection may be included in the results of an audit submitted to the health care provider.

(f) Notwithstanding subsection (c), if a health insurance entity or an agent contracted to provide eligibility verification, verifies that an individual is a covered person and if the health care provider provides services to the individual in reliance on such verification, the health insurance entity may not thereafter retroactively deny a claim on the basis that the individual is not a covered person unless such retroactive denial occurs within six (6) months of the date that the health insurance entity paid the claim; otherwise the health insurance entity is barred from making such recoupment unless there was fraud by the health care provider.

(g) If a health insurance entity chooses to recoup from a health care provider amounts previously paid under a retroactively denied

claim pursuant to subsections (c) or (e), the health insurance entity shall provide the health care provider written documentation that specifies:

(1) The amount of the recoupment;

(2) The covered person's name to whom the recoupment applies;

(3) Patient identification number;

(4) Date of service;

(5) The service or services on which the recoupment is based; and

(6) The pending or future claims being recouped.

(h)

(1) If the commissioner of commerce and insurance finds a health insurance entity has failed to comply with the provisions of this act, the commissioner may impose a penalty of two (2) times the amount of the claim or seven hundred fifty dollars ($750) whichever amount is less.

(2) In the alternative, the health care provider may seek injunctive or other appropriate relief in the chancery or circuit court in the county where the provider resides or practices.

(i) The commissioner shall adopt rules and regulations to ensure compliance with this section within one (1) year of the effective day of this act. All such rules shall be adopted in accordance with the provisions of title 4, chapter 5 and may be promulgated by public necessity rulemaking.

(j) The provisions of this act shall not be waived, voided or nullified by contract.

(k)

(1) The provisions of this act shall not interfere or otherwise repeal the following:

(A) The prompt payment appeals process described in Section 56-32-226;

(B) The authority of a receiver appointed by the commissioner of commerce and insurance pursuant to provisions of Title 56, Chapter 9 to audit or collect overpayment made to providers more than eighteen (18) months from the date that the managed care organization (MCO) paid the claim;

(C) The authority of the TennCare Bureau to collect overpayments made to providers more than eighteen (18) months from the date that the MCO paid the claim if discovered and verified by the bureau pursuant to an audit of an MCO; or

(D) The subrogation rights or authority of the TennCare Bureau.

(2) Health insurance entities that contract directly with the TennCare Bureau in the provision of services for TennCare

FILED
Date _____
Time _____
Clerk _____
Comm. Amdt. _____
_____

Amendment No. 1 to SB0460

Cooper J
Signature of Sponsor

AMEND Senate Bill No. 460* House Bill No. 1439

recipients are specifically excluded from the provisions of this act only for the products and services made by such health insurance entities on behalf of the TennCare Bureau.

SECTION 2. If any provisions of this act or the application thereof to any person or circumstance is held invalid, such invalidity shall not affect other provisions or applications of the act which can be given effect without the invalid provision or application, and that end the provisions of the act are declared to be severable.

SECTION 3. This act shall take effect January 1, 2004, the public welfare requiring it, and shall apply to contracts entered into or renewed on or after the effective date of this act.